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Appendix 1b
National HCFA 1500 Claim Form Completion Instructions
for Occupational Therapy Services and Rehabilitation Agencies

Use these claim form completion instructions to avoid denial or inaccurate claim payment. Enter all required data on the claim form in the appropriate element. Include attachments only when requested. All elements are required unless “not required” is specified.

Medicaid recipients receive an identification card when initially enrolled into Wisconsin Medicaid and at the beginning of each following month. Providers should always see this card before providing services. Please use the information exactly as it appears on the identification card to complete the patient and insured information.

Element 1 - Program Block/Claim Sort Indicator

Enter the claim sort indicator:

“T” - Occupational Therapy Services.

“M” - Rehabilitation Agency.

Claims submitted without this indicator are denied.

Element 1a - Insured's I.D. Number

Enter the recipient's 10-digit identification number from the current identification card. This element must contain no other numbers, unless the claim is a Medicare crossover claim, in which case the recipient's Medicare number may also be indicated.

Element 2 - Patient's Name

Enter the recipient's last name, first name, and middle initial from the current identification card.

Element 3 - Patient's Birth Date, Patient's Sex

Enter the recipient's birth date in MM/DD/YY format (i.e., February 3, 1955, would be 02/03/55) from the identification card. Specify if male or female with an “X.”

Element 4 - Insured's Name (not required)**Element 5 - Patient's Address**

Enter the complete address of the recipient's place of residence.

Element 6 - Patient Relationship to Insured (not required)**Element 7 - Insured's Address (not required)****Element 8 - Patient Status (not required)****Element 9 - Other Insured's Name**

You must bill health insurance (commercial insurance coverage) prior to billing Wisconsin Medicaid unless the service does not require health insurance billing according to Appendix 18a of Part A, the all-provider handbook. Leave this element blank when:

1. The provider has not billed health insurance because the “Other Coverage” of the recipient's Medicaid identification card is blank.
2. The service does not require health insurance billing according to Appendix 18a of Part A, the all-provider handbook.

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3. The recipient's Medicaid identification card indicates "DEN" only.
4. You must indicate one of the following codes in the first box of element 9 when "Other Coverage" of the recipient's Medicaid identification card indicates HPP, BLU, WPS, CHA, or OTH, and the service requires health insurance billing according to Appendix 18a of Part A, the all-provider handbook. The description is not required, nor is the policyholder, plan name, group number, etc. (Elements 9a, 9b, 9c, and 9d are not required.):

Code Description

OI-P	Use the OI-P disclaimer code when the health insurance pays in part. The claim indicates the amount paid by the health insurance company to the provider or the insured.
OI-D	Use the OI-D disclaimer code only when these three criteria are met: <ul style="list-style-type: none"> ♦ The "Other Coverage" field on the recipient's ID card shows HPP, BLU, WPS, CHA, DEN, or OTH. ♦ The service requires billing health insurance before Wisconsin Medicaid. ♦ You have billed the health insurance and received a denial from the insurance company.
OI-Y	Use the OI-Y disclaimer code when the card indicates other coverage but it was not billed for reasons including: <ul style="list-style-type: none"> ♦ The provider knows the service in question is noncovered by the insurer. ♦ Insurance failed to respond to a follow-up claim. ♦ When "Other Coverage" of the recipient's Medicaid identification card indicates "HMO" or "HMP," one of the following disclaimer codes must be indicated if applicable:

Code Description

OI-P	Use the OI-P disclaimer code when the health insurance pays in part. The amount paid is indicated on the claim.
OI-H	Use the OI-H disclaimer code only when these two criteria are met: <ul style="list-style-type: none"> ♦ The "Other Coverage" field on the recipient's ID card is HMO or HMP. ♦ The HMO or HMP does not cover the service or the billed amount does not exceed the coinsurance or deductible amount.

Note: You may *not* use OI-H if the HMO or HMP denied payment because an otherwise covered service was not rendered by a designated provider. Wisconsin Medicaid does not reimburse services covered by an HMO or HMP except for the copayment and deductible amounts. Providers who receive a capitation payment from the HMO may not bill Wisconsin Medicaid for services which are included in the capitation payment.

Element 10 - Is Patient's Condition Related to (not required)

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Element 11 - Insured's Policy, Group, or FECA Number

Use the *first* box of this element for Medicare information. (Elements 11a, 11b, 11c, and 11d are not required.) Medicare must be billed before billing Wisconsin Medicaid. When the recipient's identification card indicates Medicare coverage, but Medicare does not pay, indicate one of the following Medicare disclaimer codes. The description is not required.

Code Description

M-1 Medicare benefits exhausted. This code applies when Medicare has denied the claim because the recipient's lifetime benefit, spell of illness, or yearly allotment of available benefits is exhausted.

Use M-1 in these two instances only:

For Medicare Part A (all three criteria must be met):

- ◆ The provider is certified for Medicare Part A.
- ◆ The recipient is eligible for Medicare Part A.
- ◆ The procedure provided is covered by Medicare Part A but is denied due to benefits being exhausted.

For Medicare Part B (all three criteria must be met):

- ◆ The provider is certified for Medicare Part B.
- ◆ The recipient is eligible for Medicare Part B.
- ◆ The procedure provided is covered by Medicare Part B but is denied due to benefits being exhausted.

M-5 Provider not Medicare certified. This code applies when the provider is not required by Wisconsin Medicaid to be Medicare Part A or Part B certified, has chosen not to be Medicare Part A or Part B certified, or cannot be Medicare Part A or Part B certified.

Use M-5 in these two instances only:

For Medicare Part A (all three criteria must be met):

- ◆ The provider is not certified for Medicare Part A.
- ◆ The recipient is eligible for Medicare Part A.
- ◆ The service is covered by Medicare Part A.

For Medicare Part B (all three criteria must be met):

- ◆ The provider is not certified for Medicare Part B.
- ◆ The recipient is eligible for Medicare Part B.
- ◆ The service is covered by Medicare Part B.

M-6 Recipient not Medicare eligible. This code applies when Medicare denied the claim because there is no record of the recipient's eligibility. Use M-6 in these two instances only:

For Medicare Part A (all three criteria must be met):

- ◆ The provider is certified for Medicare Part A.
- ◆ The service is covered by Medicare Part A.
- ◆ The recipient is not eligible for Medicare Part A.

For Medicare Part B (all three criteria must be met):

- ◆ The provider is certified for Medicare Part B.

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- ♦ The service is covered by Medicare Part B.
- ♦ The recipient is not eligible for Medicare Part B.

M-7 Medicare disallowed or denied payment. This code applies when Medicare actually denies the claim for reasons given on the Medicare remittance advice. Use M-7 in these two instances only:

For Medicare Part A (all three criteria must be met):

- ♦ The provider is certified for Medicare Part A.
- ♦ The recipient is eligible for Medicare Part A.
- ♦ The service is covered by Medicare Part A but is denied by Medicare Part A.

For Medicare Part B (all three criteria must be met):

- ♦ The provider is certified for Medicare Part B.
- ♦ The recipient is eligible for Medicare Part B.
- ♦ The service is covered by Medicare Part B but is denied by Medicare.

M-8 Noncovered Medicare service. This code applies when Medicare was not billed because Medicare does not cover the service at this time. A list of services that are not covered under Medicare is in Appendix 16 of Part A, the all-provider handbook.

Nursing homes must use M-8 for Medicare-eligible recipients who are hospitalized and do not wish to return to a Medicare-covered bed.

For Medicare Part A (all three criteria must be met):

- ♦ The provider is certified for Medicare Part A.
- ♦ The recipient is eligible for Medicare Part A.
- ♦ The service is not covered under Medicare Part A.

For Medicare Part B (all three criteria must be met):

- ♦ The provider is certified for Medicare Part B.
- ♦ The recipient is eligible for Medicare Part B.
- ♦ The service is not covered under Medicare Part B.

Leave the element blank if Medicare is not billed because the recipient's Medicaid identification card indicated no Medicare coverage.

Leave the element blank if Medicare allows an amount on the recipient's claim. Attach the Explanation of Medicare Benefits (EOMB) to the claim. Do not enter Medicare paid amounts on the claim form. Refer to Appendix 17 of Part A, the all-provider handbook, for more information about the submission of claims for dual-entitlees.

Elements 12 and 13 - Authorized Person's Signature

(Not required since the provider automatically accepts assignment through Medicaid certification.)

Element 14 - Date of Current Illness, Injury, or Pregnancy (not required)

Element 15 - If Patient Has Had Same or Similar Illness (not required)

Element 16 - Dates Patient Unable to Work in Current Occupation (not required)

Element 17 - Name of Referring Physician or Other Source

Enter the referring or prescribing physician's name.

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Element 17a - I.D. Number of Referring Physician

Enter the referring provider's six-character UPIN number. If the UPIN number is not available, enter the Medicaid provider number or license number of the referring provider. Refer to Appendix 3 of Part A, the all-provider handbook, for the UPIN directory address.

Element 18 - Hospitalization Dates Related to Current Services (not required)**Element 19 - Reserved for Local Use**

If an unlisted procedure code is billed, describe the procedure. If element 19 does not provide enough space for the procedure description, or if multiple unlisted procedure codes are being billed, attach documentation to the claim describing the procedure(s). In this instance, indicate "See Attachment" in element 19.

Element 20 - Outside Lab (not required)**Element 21 - Diagnosis or Nature of Illness or Injury**

Enter *The International Classification of Diseases, 9th Revision, Clinical Modification* (ICD-9-CM) diagnosis code for each symptom or condition related to the services provided. Manifestation ("M") codes are not acceptable. List the primary diagnosis first. Etiology ("E") codes may not be used as a primary diagnosis.

Element 22 - Medicaid Resubmission (not required)**Element 23 - Prior Authorization**

Enter the seven-digit prior authorization number from the approved prior authorization request form. Bill services authorized under multiple prior authorizations on separate claim forms with their respective prior authorization numbers.

Element 24a - Date(s) of Service

Enter the month, day, and year for each procedure using the following guidelines:

- ◆ When billing for one date of service, enter the date in MM/DD/YY format in the "From" field.
- ◆ When billing for two, three, or four dates of service on the same line, enter the first date of service in MM/DD/YY format in the "From" field, and subsequent dates of service in the "To" field by listing *only* the date(s) of the month (e.g., DD, DD/DD, or DD/DD/DD).

It is allowable to enter up to four dates of service per line if:

- ◆ All dates of service are in the same calendar month.
- ◆ All services are billed using the same procedure code and modifier if applicable.
- ◆ All procedures have the same type of service code.
- ◆ All procedures have the same place of service code.
- ◆ All procedures were performed by the same provider.
- ◆ The same diagnosis is applicable for each procedure.
- ◆ The charge for each procedure is identical. (Enter the total charge *per detail line* in element 24f.)
- ◆ The number of services performed on each date of service is identical.
- ◆ All procedures have the same HealthCheck indicator.
- ◆ All procedures have the same emergency indicator.

Element 24b - Place of Service

Enter the appropriate *single-digit* place of service code for each service. Refer to Appendix 3 of this handbook for a list of allowable place of service codes for occupational therapy services.

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Element 24c - Type of Service Code

Enter the appropriate single-digit type of service code. Refer to Appendix 3 of this handbook for a list of allowable type of service codes for occupational therapy services.

Element 24d - Procedures, Services, or Supplies

Enter the appropriate five-character procedure code and, if applicable, a maximum of two, two-character modifiers. Refer to Appendix 4 of this handbook for a list of allowable procedure codes for occupational therapy services.

Element 24e - Diagnosis Code

When multiple procedures related to different diagnoses are submitted, use column E to relate the procedure performed (element 24d) to a specific diagnosis in element 21. Enter the number (1, 2, 3, or 4) which corresponds to the appropriate diagnosis in element 21.

Element 24f - Charges

Enter the total charge for each line.

Element 24g - Days or Units

Enter the total number of services billed for each line. Occupational therapy services must be billed following the *Conversion of Therapy Treatment Time Guidelines* in Appendix 5 of this handbook.

Element 24h - EPSDT/Family Planning

Enter an "H" for each procedure that was performed as a result of a HealthCheck (EPSDT) referral. If HealthCheck does not apply, leave this element blank.

Element 24i - EMG

Enter an "E" for *each* procedure performed as an emergency regardless of the place of service. If the service is not an emergency, leave this element blank.

Element 24j - COB (not required)**Element 24k - Reserved for Local Use**

Enter the eight-digit provider number of the performing provider *for each procedure* if it is different than the billing provider number indicated in element 33.

Note: Rehabilitation agencies do not indicate a performing provider number.

When applicable, enter the word "spenddown" and under it, enter the spenddown amount on the last detail line of element 24k directly above element 30. Refer to Section IX of Part A, the all-provider handbook, for information on recipient spenddown.

Any other information entered in this column may cause claim denial.

Element 25 - Federal Tax ID Number (not required)**Element 26 - Patient's Account No.**

Optional - The provider may enter up to 12 characters of the patient's internal office account number. This number appears on the fiscal agent Remittance and Status Report.

Element 27 - Accept Assignment

Not required. Provider automatically accepts assignment through Medicaid certification.

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Element 28 - Total Charge

Enter the total charges for this claim.

Element 29 - Amount Paid

Enter the amount paid by the health insurance. If the other health insurance denied the claim, enter \$0.00. (If a dollar amount is indicated in element 29, "OI-P" must be indicated in element 9.)

Element 30 - Balance Due

Enter the balance due as determined by subtracting the recipient spenddown amount in element 24k and the amount paid in element 29 from the amount in element 28.

Element 31 - Signature of Physician or Supplier

The provider or an authorized representative must sign in element 31. Also enter the month, day, and year the form is signed in MM/DD/YY format.

Note: This may be a computer-printed or typed name and date, or a signature stamp with the date.

Element 32 - Name and Address of Facility Where Services Rendered

If the services were provided to a recipient in a nursing home (place of service 7 or 8), indicate the nursing home's eight-digit provider number.

Element 33 - Physician's, Supplier's Billing Name, Address, Zip Code, and Telephone #

Enter the billing provider's name (exactly as indicated on the provider's notification of certification letter) and address. At the bottom of element 33, enter the billing provider's eight-digit provider number.